CDC *Vital Signs* Town Hall Teleconference on
Cardiovascular Disease: High Blood Pressure and Cholesterol
Transcript

February 8, 2011
2:00pm – 3:00pm EST

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode until the question and answer period. If you would like to ask a question at that time, please press star then 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I'd like to turn over the meeting to Dr. Judy Monroe. You may begin.

Dr. Judy Monroe: Well good afternoon everyone and I want to welcome everyone to our February CDC *Vital Signs* town hall teleconference. This is hosted by the Office for State, Tribal, Local and Territorial Support. I'm Dr. Judy Monroe and I direct OSTLTS, the acronym that we use for the office. And our topic today is the leading cause of death in this country, which of course is heart disease.

I hope everyone's had an opportunity to read this month's *Vital Signs* since its release last Tuesday. And when you read it, it clearly shows that we have a lot of work ahead if we're going to get under control in the U.S. population two of the major risk factors for heart disease – those being high blood pressure and cholesterol.

Joining us today to discuss their important work in addressing this challenge through policy changes and health systems improvement are public health colleagues from CDC's Division for Heart Disease and Stroke Prevention, Kansas Department of Health and Environment and California's Department of Managed Healthcare.

But first I'm really pleased to introduce Lynn Sokler. She is the CDC *Vital Signs* Program Communication Director and Senior Communication Advisor from the Office of the Associate Director for Communication. Lynn will be serving as our moderator for today's discussion.

Before I turn it over to Lynn, I just want to give you a reminder that the PowerPoint for today's presentations is now available on the OSTLTS' Website, which is www.cdc.gov/ostlts. Simply click on the town hall in the flash module to get that. Now we did hear that there are some folks having a little trouble with the PowerPoint. So if you do find that it doesn't come up on your screen, then right click and hit save as, and it should save to your computer and you should be able to follow along on the PowerPoint slides as our speakers go through their presentations.

Once you are on that page, when you are on the—looking at the town hall [page from] the flash module, that page—you're also going to find a short feedback survey. After the call, we just want to ask you to take a moment and share your thoughts on how we might improve these monthly teleconferences.

So without further adieu, let me turn it over to Lynn Sokler.

Lynn Sokler: Thank you Dr. Monroe and it's a pleasure to be here everyone. Our presentations today, as you know, this *Vital Signs* is on cardiovascular disease, specifically high blood pressure and cholesterol. And we're going to have presentations today that show some of the wide strategies that are being used across the country to address the growing epidemic of heart disease.

We want—I know you're going to enjoy hearing from these people, but more importantly it's important for us to hear from you. So at the end of these presentations, I'm going to lead a moderated discussion. And discussion is the nature of the word. In other words, we can't learn from you and others on the

phone can't learn from you if you don't share with us. And so I'm going to be asking you to do that.

But first today you're going to hear from Darwin Labarthe, who is the Director of the CDC's Division for Heart Disease and Stroke Prevention in the National Center for Chronic Disease Prevention and Health Promotion. [That's] a big mouthful, but he's going to talk today about this month's *Vital Signs* report and give us the national perspective on this deadly yet very preventable disease.

Then we're going to hear from Paula Clayton, who is Director of the Bureau of Health Promotion at the Kansas Department of Health and Environment. She's been facilitating the development of broad public private partnerships to support chronic disease in this state and she's going to talk about some of the successes and some of the challenges that she's had in implementing an initiative for reducing sodium in Kansas.

We'll also hear from Hattie Rees Hanley who is the Director of the Right Care Initiative Program in the [California Department of Managed Health Care]. That program works to improve systems of care related specifically to hypertension and cholesterol and improving patient outcomes and control of their conditions.

As I said, we're going to have a half-hour of question and answer following these speakers. I'm really going to be very excited to hear your feedback and learn what—how you're using *Vital Signs* in your state. So I'll turn it over to Darwin Labarthe at this point.

Dr. Darwin Labarthe: Thank you very much Lynn and Judy. When we in the Division for Heart Disease and Stroke Prevention at CDC check on the nation's vital signs we find that high blood pressure and cholesterol are out of control. And that is the

message of *Vital Signs* for February 2011. To know about the details of our reports and the materials that are provided, you may go to cdc.gov/vitalsigns, and for the *Morbidity and Mortality Weekly Report* accounts to cdc.gov/mmwr for the whole story.

Today we will offer just some brief highlights, as well as the two presentations that Lynn announced a moment ago from speakers who are on the front lines of prevention and public health and then an opportunity for us to hear your comments and ideas.

The next slide summarizes some highlights of the February 2011 CDC *Vital Signs* report on high blood pressure and cholesterol. It notes that cardiovascular disease kills more than 800,000 U.S. adults each year. If you ask the question, "How many people under age 65 should die of a preventable disease?" the answer is zero. Yet, 150,000 adults under age 65 die of these conditions every year. That's more than 400 every day, day in and day out, in the United States. Why? Very largely because high blood pressure and high LDL cholesterol are out of control. The numbers speak for themselves—68 million U.S. adults have high blood pressure, and about half don't have their blood pressure under control. For high LDL cholesterol, 71 million U.S. adults have high values and nearly two out of three don't have their condition under control. If you ask the next logical question, "How many have both?" about 100 million, or half of the U.S. adult population, have both high blood pressure and high LDL cholesterol.

We've noted, in the process of checking the nations pulse, that more than 80% of people with uncontrolled high blood pressure or cholesterol already have health insurance. That's not to say health insurance is unimportant because twice as many as those without insurance as those with insurance are uncontrolled on these two major factors. This simply makes the point that

while having health insurance is essential, it is not a guarantee that these major conditions will be controlled.

Our Director, Dr. Tom Frieden, quoted by the Internal Medicine News recently, pointed to many examples of health systems, health programs, doctors' offices using information technology to support patients and drastically improve the levels of control. And as he pointed out, that's something needed throughout the healthcare experience in this country. Improving how healthcare is delivered in our country can only help us improve these numbers and the health of all Americans.

The figures I mentioned earlier, about half of those with high blood pressure not having it under control, about 1/3 of those—only 1/3 of those with high LDL cholesterol who do have it controlled, means about 46% of hypertensives, 33% of those with high cholesterol have their risk factors controlled. We can ask how good can it get? We have seen in a number of health systems that the proportionate people with high blood pressure, for example, who have it controlled can easily reach 65% or even above 85%. And so we have a tremendous opportunity to make the most effective provisions of the most effective systems more widely available to have a real impact.

The next slide then turns to the question what could be done? And we can think of this at several levels. The Affordable Care Act itself expands health insurance coverage and covers preventive services, potentially for tens of millions more Americans.

Policymakers can develop programs and policies to increase chronic disease prevention and management. They can champion policies to improve the food supply, including reduction of sodium content of our foods, as we'll hear more about this afternoon.

Doctors, nurses, other healthcare providers can work with patients more effectively to manage conditions at every opportunity. Current guidelines and technology can help to guide practice for the benefit of provider systems and, more importantly, their patients.

Individuals themselves can make healthy lifestyle choices, where the environment makes this possible, following doctor's instructions, staying on medications, but much work needs to be done to improve the food environment and the physical environment to make healthy choices possible.

So if we think about the opportunities to make progress in dealing with our problem of uncontrolled high blood pressure and cholesterol, we see efforts through the federal initiatives of the Affordable Care Act; policymakers at all levels of government and organizations; doctors, nurses and other healthcare providers at work; and individuals making healthy lifestyle choices the easier choices.

The last slide turns to the key question of what you can do. You can use *Vital Signs* to bring attention to high blood pressure and high cholesterol. As I mentioned earlier, you can readily access the Websites at CDC for the materials developed for *Vital Signs* and for the *MMWR* publications that stand behind them.

You can champion policies that promote healthy foods and beverages. You can create and implement statewide systems of care. You can support policies for other healthcare professionals to help manage high blood pressure and cholesterol more effectively, learning from the experience of some of those who have achieved exceptionally high rates of control. It can be done. It is being done. It needs to be done more widely.

You can promote effective disease prevention and chronic disease management and you can improve access to medications. What if, for example, co-pays were reduced or eliminated? What if simple medication regimens were readily available at low cost to patients with longer-term prescriptions that less often require the special effort for prescription renewal?

These are just some indications of what you can do to improve the control of high blood pressure and cholesterol in your communities, in your states, and for those of you who are in direct patient care, for your patients.

So I very much appreciate the opportunity to provide this brief introduction to *Vital Signs*, encourage you to look further into the materials that we have prepared for your information, and look forward to your comments and ideas in the discussion period. Thank you very much.

Lynn Sokler: Thank you Dr. Labarthe. We'll turn now to Paula Clayton with the Kansas City Department of Health. I mean the Kansas State Department of Health, Paula.

Paula Clayton: Thank you. I am really pleased today to provide a brief overview of the Sodium Reduction in Communities Project that we are involved in here in Kansas, which is focused very specifically on sodium and its impact with controlling blood pressure and where we're hoping and working to put into place some of the recommendations that Dr. Labarthe just laid out. Misty Jimerson, our State's Heart Disease and Stroke Program Manager, is also joining me here today.

Kansas received one of the small state, small city grant awards to conduct a Sodium Reduction in Communities project. In this case, the state health agency serves as the fiduciary lead agency for the project and our local partner and lead agency at the community level in this effort is the Shawnee County

Health Agency, along with their established Heartland Healthy Neighborhood Coalition.

On the first slide after the title slide there, you'll note the project leadership. This coalition is led by a very highly effective group of community leaders that blossomed as a designated Pioneering Healthy Communities project in 2008. The leadership of the coalition is listed on the right side of that slide. The project is located here in Shawnee County where Topeka, the capital city and largest city in Shawnee County, is located.

The agencies that are leading the project (that are listed there) are fully engaged in implementing specific strategies in two categories that are listed on the left side of the slide in detail—strategies related to policy, systems, and environmental change and media strategies.

So while CDC and its partners at the national and international levels are working with food manufacturers and retailers to reduce the amount of sodium in processed food formulation, our partners will be working with the purchasers of foods and food products here at the community level.

We will be working with government purchasers who purchase food for meetings, cafeterias, vending, concessions, including ballparks throughout the county, to identify lower sodium options and to adjust procurement practices to reduce the amount of invisible sodium in foods that are purchased by government sources.

Similarly, private employers, beginning with those who have been most actively involved in the Heartland Healthy Neighborhood activities, will be engaged in strategies to reduce the invisible sodium content in foods as well, in foods that are offered though their cafeterias, meetings, vending, etcetera.

So in a sense, this activity will drive demand for processed and ready to eat foods that are available for retail purchase by Shawnee countians.

The local medical society will also play an active role in this project. System changes, as Dr. Labarthe noted, include an important role for health professionals as they assist their patients in making the connection between sodium and blood pressure. The local medical association of Shawnee County and the cooperative extension service are taking the lead in developing a technical assistance and training approach to assist primary care practitioners in promoting low sodium eating practices throughout their patient populations.

Along with the focus in reducing sodium in processed and purchased foods, the HHN will expand current promotions of fruits and vegetables consumptions. Slide Number 2—and they'll do this in two major ways—slide Number 2 illustrates the first way by expanding the availability of locally grown fresh fruits and vegetables through farmers markets. And they'll also be using price as an incentive to promote purchase of fruits and vegetables in a number of settings in Shawnee County.

This is important because—the farmers market concept—because downtown Topeka is home to over 30,000 employees that include—the employers include several state agencies, along with major non-government business employers. So within a mile radius we have about 30,000 employees in downtown Topeka. In the past, the Downtown Business Wellness Coalition, which is part of the Healthy Heartland Neighborhood, established a mid-week capital farmers market that has expanded already to another location on a different day of the week. And the mid-week farmers markets have become very popular among our downtown employees, providing not only a walking destination, but 90% of market-goers are reporting that having the market available during the summer months as part of their workday has increased their consumption of fruits and vegetables.

As you can also note from this slide, the market is good for the Topeka economy. We had partnered with the Kansas Rural Center, who conducted a rapid market analysis of our mid-week market here in the downtown area, which of course—actually right on the grounds of the state capital building. They estimated that each market generated nearly $10,000 in sales and generated over $14,000 in taxes for the City of Topeka during the market season.

As you move to the third slide, this is giving you a glimpse of our recent announcement to the general public that occurred as a press event, along with a meeting of the Heartland Healthy Neighborhood Advisory Council, which includes leaders of business, government, non-profit and elected leaders of both the Topeka and Shawnee County communities. At that time we had the opportunity to discuss, in a public forum, the positive impact to health that can be expected from the measures and the strategies that were proposed.

Activities during this first year include a community assessment using the change tool developed by CDC that will provide a baseline measure of current purchasing practices and policies among employers, as well as identify ways to use price as incentives for behavior change, particularly as it relates to consumption of fruits and vegetables.

We will be conducting a countywide Sodium Reduction in Communities survey that uses BRFS [Behavioral Risk Factor Survey] telephone methodology, direct physical measures and dietary recall of survey participants. These baseline measures will provide us with a solid foundation of the current status of the impact of sodium on cardiovascular health, as well as provide critical information about how Shawnee countians currently make food choices, helping us to identify opportunities for Shawnee countians to reduce sodium in their food environment. We were very pleased to have our CDC project officers join us for the press event that is pictured here and

you're seeing some of the clippings there. It generated an amazing amount of press and some very interesting comments on the blogs. One of the members of our Heartland Healthy Neighborhood leadership team is the general manager of the largest television station here in the Topeka area and provided us with some really helpful guidance as we use media to communicate the message and also to interpret the response that we're hearing from the public and from leaders of the business community as well.

So we're just getting off and started with—we're just into the first few months of this project and look forward to implementing these pro—the strategies that were laid out over the next few years. Thank you.

Lynn Sokler: Thank you so much Paula. That was really interesting. And you've got a lot of different things going on that I'm sure are going to pay off. Next we're going to hear from Hattie Rees Hanley from the [California Department of Managed Health Care] about the Right Care Initiative Program, so Hattie.

Hattie Rees Hanley: Hi. The name of my department is actually the California Department of Managed Health Care and in California we regulate the healthcare for 21 million commercial enrollees. We are a state of 38 million people and our department is not co-located with the Department of Public Health. However, I want to acknowledge their very important work at the Department of Public Health. They have been providing great moral support and technical support. And because of our budget issues, I have to say that we have primarily run this project out of private donations thus far from Johnson & Johnson for gathering meetings.

So what I should say is that our department is a pretty new department. It's about 10 years old and in the founding legislation for the Department of Managed Health Care, the concept was to ensure the quality of care and the solvency of the provider model that we're regulating here. Because this is a

pre-paid model of care similar to what is being talked about nationally with the ACO [Accountable Care Organizations] model, the Kemble Care Organization.

So when I first came to the department in 2006, my Director, Cindy Ehnes, asked me if I could develop a clinical quality improvement program largely because our department was positioned in an only reactive mode and we were reacting to some really large quality problems with some of our major HMOs, health plans in California. For instance you probably heard about some kidney transplant programs shutting down here, etcetera, related to some California HMOs.

So what I did to start this project is to analyze the available data. And what stuck out to me, as a child who at the age of 15 lost my mother to a stroke – she had uncontrolled high blood pressure, when I saw that the between 30 and 40% of patients in California HMOs had their blood pressure and LDL lipids out of control, I thought well here's an opportunity to proactively work with the medical directors of California on something where we have clear science and we have good, cheap generic medications. We know how to handle these problems at this time. Whereas we didn't back in 1976 quite have the number of tools that we have available now.

So I started in 2007 having discussions with NCQA [National Committee for Quality Assurance]**,** with Rand, with the medical directors of the big HMOs in California and the provider groups. And what I did, because my training is really in public policy analysis grounded in numbers, is I asked the National Committee for Quality Assurance to do a special analysis for us showing how did the California HMOs' performance compare to the rest of the country with regard to hypertensive patients, cardiovascular disease patients and diabetes patients. And I should say that they did a special run comparing the California

performance compared to the nation. And I'm sorry these slides aren't in perfect order. And I should...

Lynn Sokler: Hattie, excuse me for interrupting you for a moment. But we have about four, three minutes left. And I think we're all a little confused maybe about where you are in your slides. So if you could let us know that.

Hattie Rees Hanley: Okay so let's, after the—sorry I wasn't really going by the slides—so half the first slide you see the actual goals. So those are, we created goals of reaching the national 90th percentile of performance for blood pressure and lipids as our top goals. And that's what links to this. So that would mean that 70% of hypertensive and cardiovascular patients would be at goal. And you see those goals. Those are goals that were nationally derived through NCQA.

The next slide, with the triangle on it, shows the array of promising interventions for getting to goal that we have gathered in California. And I should just highlight that the primary approaches as [we go] through this slide. At the apex of this slide, you see the patient activation. Yes, we need the healthy guidance, which we just heard about: exercise, medication adherence, evidence-base education of the patients and motivational media messaging, which we're working on in a San Diego pilot project now.

Then you also see two other critical promising interventions: clinical pharmacists on the care team and the medication protocols, and that's actually how I met Darwin Labarthe on January 20. He came out to a conference that we held at UC San Diego Faculty Club on the potential of spreading a very effective medication, simple medication protocol that Kaiser has developed and used.

And what you'll see in the next slide—in the California performance, which shows controlling high blood pressure where the California plans stand for blood pressure and lipid control compared to the best in the nation.

And I think these best in the nation—so if you look at the slide that says "California versus national top 10 HEDIS scores," you'll see on the left-hand side of that slide—the top half, the upper left quadrant of this slide— you'll see the California actual performance. You see that Kaiser has between 80 and 84% of their patients under control for blood pressure. The network model plans you see are between 62% and 71% with blood pressure under control; and actually that's a great deal of performance improvement since we started pushing on the plans to improve in these two critical measures that are highlighted in this month's *Vital Signs*.

But you see at the bottom half of the slide where the best plans in America are performing. And this is something where we could really use CDC's help. So we see that in the best plans in the country are perform—have between 76% and 87% of their patients at control for blood pressure. And you see that for LDL control, between 73% and 81% are at goal for LDL 100.

Then you see at the very—the next slide shows you that in San Diego County we're drilling down to see what's the specific performance by medical group. And that ranges between, you know, the four big medical groups in San Diego. You see UC San Diego Medical Group at about half of their patients at goal for LDL control and you have Scripps and Sharp performing at approximately the national 90th percentile performance.

So what we've done in San Diego is we have launched, and actually yesterday we had our inaugural meeting of something we're calling the University of Best Practices to get all these medical groups together to start sharing best

practices and drilling down on how can they can adopt the best practices that we've identified and are yet to be identified with your help at CDC.

And the very last slide just shows the impressive array of partners that we've gathered in the State of California to work with us on this. And with this, I'll close because I'm sure I'm at time.

Lynn Sokler: Thank you very much Hattie. That was really interesting. One of the - I have an immediate question for you which was have you done any analysis to determine how these prac—what these practices are doing to drive control?

Hattie Rees Hanley: Well that's what you see if you go back to the triangle slide, the aqua triangle slide, which I think is the third slide. It says "Promising Interventions to Reach HEDIS Control Targets for Heart Attack and Stroke Prevention." This is based on my interviewing medical directors, not only in California and around the country because I have made calls to those high performing medical directors in the plans outside of California. And I have to say I haven't been able to do a truly analytical job. Frankly this triangle is a synthesis of just all the best information I was able to hear from those interviews.

So what my steering committee in San Diego has determined is that they believe that spreading simple medication protocols, like what Darwin mentioned a few moments ago, is probably the quickest way to get patients to goal. Because what we found in California, the California Medical Association Foundation did a survey that showed that approximately half of the time, when a patient comes in with high blood pressure, they're not coming in for that reason and so the doctor focuses on something else. The patient ends up leaving the office with no action taken related to that high blood pressure, no counseling, no prescription. So what we'd like to do is have some simple protocols that people can agree too, whether it's the, as you

see in the bottom right corner of that triangle, the Kaiser ALL/PHASE project—which I can go into or Darwin can go into—or the EU guidelines which are much more complex.

So the conference that we did on January 20, which was a consensus conference, was really around—the Kaiser protocol and the European protocol are really very different. But the Kaiser protocol has simplicity that enables sort of a baseline of action for providers to take every single time they come across...

Lynn Sokler: That's great. Hattie, thank you so much for your presentation. I'm sure everybody was very, very interested in your findings. I'd like to open it up for questions to our speakers. And we'll do that for a few minutes. So is there anyone who has a speak—a question operator?